Dermal Filler Consent form

Patient's Name and DOB _____

Consent for treatment of Dermal Fillers such as Juvederm and Restylane to smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. I understand dermal fillers are injected under the skin with a very fine needle. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately. Its effect can last up to 6 months. Most patients are pleased with the results of dermal fillers use.

I understand dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines and folds in the skin on the face.

I understand I might require additional treatment to achieve the results I seek.

I understand the dermal filler procedure is temporary and additional treatments will be required periodically, generally within 4-6 months, involving additional injections for the effect to continue. I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have or have not had any major illnesses which would prohibit me from receiving dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine or Hyaluronic acid.

I understand No procedure is completely risk-free. Although the majority of patients do not experience these complications it has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, bruising, and discoloration; 2) Post treatment infection which is extremely rare; 3) Allergic reaction; 4) Reactivation of herpes (cold sores); 5) Lumpiness and/or Granuloma formation; 7) Localized ischemia and/or sloughing, with scab and/or without scab.

I am aware that follow-up treatments will be needed to maintain the full effects I have been instructed in and understand the post-treatment instructions.

I authorize the taking of clinical photographs for scientific use in publications, presentations, and my medical record. I understand my identity will be protected.

I understand this is an elective procedure and I hereby voluntarily consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and replacing facial volume. I understand that this is an "elective" procedure and alternatives to the procedures and options have been fully explained to me and that payment is my responsibility and is expected at the time of treatment. I understand that any treatment performed is between me and the Royal Medical Health provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician.

By signing this consent form I hereby voluntarily consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and replacing facial volume. The procedure has been fully explained to me. I also understand I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history medications or my physical conditions I will notify the Royal Medical Health provider who treated me, immediately. I also state that I read and write in English.

I have answered these questions truthfully. I have viewed the Privacy Policy. I give permission to leave detailed messages, fax or e-mail information regarding my care, and/or discuss my medical care with specific family and/or friends, or other healthcare professional when is necessary. I understand that I am granting a waiver of my privacy rights under HIPAA. If I decide to change these instructions, I will notify Royal Medical Health provider in writing as soon as possible. If I have given my email address above, I understand that email is not privacy protected.

Type text here

Patient's Signature and Today's Date _____